			PRA	<b>ACTICE MEMBER</b>	REGISTRATIC	N FORM	FILE #:				
NAME					HOME #						
ADDRESS						CELL/WORK #					
CITY/STATE/ZIP						E-MAIL					
EMERGENCY CO	NTACT & PHONE	E	SPC	OUSE NAME		NAMES & AGES OF CHILDREN					
O MALE	O Single O	Divorced	3	DATE OF		REFERRED BY PRIVATE PHYSICIAN					
O FEMALE	O Married O			BIRTH							
	THOD OF CONTA	CT: E	EMAIL	ТЕХТ			d/or email appointment				
CELLULAR PRO			17		reminder. Plea	se notify the staff if you	do not want to receive this.				
		OMPLAIN	v /								
				PLEASE DESCRIBE	PLEASE DESCRIBE YOUR SYMPTOMS INCLUDING ONSET DATE						
					PLEASE RATE YOUR PAIN: 0 1 2 3 4 5 6 7 8 9 10						
						lo Pain	Severe Pain				
-	$\bullet$ O ankle	O foot	PAIN	PLEASE DESCRIBE	YOUR PAIN:						
O OTHER explain	1:			O Sharp O Dull	O Shooting O Bu	Irning O Throbbing O N	umb O Tingling				
				HOW LONG DOES P	-						
IT IS: O CONST	ant 76-100% C	FREQU	ENT 5	51-75% O OCCASIO	NAL 26-50% OI	NTERMITTENT 0-25%					
DOES PAIN SPR	EAD TO OTHER A	REAS?	IF SO	, WHERE?							
DOES ANYTHING	G AGGRAVATE TH	НЕ СОМ	PLAIN	Τ?							
SPECIFIC INJUR	Y? O YES	O no	PRIC	DR TREATMENT?	O yes O	NO					
HAD TREATMENT? O YES O NO TX TYPE: O Drugs O Nv Block O Phys Therapy O Surgery O Xray O MRI O EMG											
			TX T	TPE: O Diugs O	INV BIOCK O Phy	s Therapy O Surgery	O Xray O MRI O EMG				
MEDICAL HISTO		U NO	TX T NO	TFE: O Drugs O		rs Therapy O Surgery	O Xray O MRI O EMG				
				LIST MEDICATION			O Xray O MRI O EMG				
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MEDICAL HISTO ARTHRITIS		YES	NO O	LIST MEDICATION		UPPLEMENTS	O Xray O MRI O EMG				
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RECREATIONAL ACTIVITIES / LIFESTYLE (hobbies, level of exercise, alcohol, tobacco and drug use, diet) :

Practice Member Name: \_\_\_\_\_

Date: \_\_\_\_\_

# Terms of Acceptance

## **Informed Consent:**

A practice member, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the practice member in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the practice member susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the practice member to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a practice member by a physician at The Drugless Doctors, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

#### Circle one

Women Only: Circle one

To the best of my knowledge (I am / am NOT) pregnant and (give permission / don't give permission) to x-ray me for diagnostic interpretation. Pregnancy Complications:

## **Missed Appointments:**

There is a possible cancellation fee charged for appointments that are not canceled in advance. Visits missed while on a care plan must be made up within the time frame of the care plan.

## **Guarantee of Results:**

The purpose of chiropractic care is to improve the health and function of the spine and nervous system. It is not to treat disease, suppress symptoms, medically diagnose, perform surgery or prescribe medications. If you desire any of these we will gladly refer you for those services. Practice member acknowledges that any and all questions regarding benefits, risks and alternatives have been answered to their satisfaction.

#### **Communications:**

In the event that we would need to communicate your healthcare information, to whom may we do so?

Please indicate if our office can leave a message on your voicemail regarding your personal health information. Y [] N []

Please indicate if we can text office updates in the case of weather alerts or special office announcements. Y [] N []

Please indicate if we can send email information to the provided email address through unsecure means. Y [] N []

Preferred Communication Voicemail Y/N Text Y/N Email Y/N

## **Release of Medical Information:**

I certify that I (or my dependent) assign directly to The Drugless Doctors all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize this office to release any information requested by my insurance company to document my claim for benefits. I understand that I am personally responsible for full payment of all charges for my treatment. Services are payable at the time rendered. X-rays remain the property of this clinic and will only be released to another physician after receiving a proper release authorization request from said physician. X-ray will not be released directly to practice members.

## **Determination of Treatment:**

I understand and agree that the doctors of The Drugless Doctors have the right to decline or accept me as a practice member at any time before treatment begins. Taking a history and conducting an examination are a part of the process of information gathering, so that the doctor can determine whether to admit me as a practice member or not.

# Minor Consent:

I am authorized to and do consent to all treatments performed by the doctors and staff of The Drugless Doctors and rendered to the minor practice member named on this registration form.

## Acknowledgement:

I have read and fully understand the above statements. I have received and/or reviewed the notice of privacy practices (HIPAA-Posted at druglessdrs.com/new-member-info) and understand that I have the opportunity to discuss my right to privacy upon request.

Print Name: \_\_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_



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Name:					File N	umber: _			_ Date:			
Please CIRCLE a number to rate	each functio	n below.										
	0= <u>BEST</u>						10	= <u>WORST</u>				
1. Overall Quality of Life:	0	1	2	3	4	5	6	7	8	9	10	
2. Sleep Habits:	0	1	2	3	4	5	6	7	8	9	10	
3. Energy Levels:	0	1	2	3	4	5	6	7	8	9	10	
4. Behavior:	0	1	2	3	4	5	6	7	8	9	10	
5. Attention:	0	1	2	3	4	5	6	7	8	9	10	
6. Activity Levels:	0	1	2	3	4	5	6	7	8	9	10	
7. Co-ordination:	0	1	2	3	4	5	6	7	8	9	10	
8. Appetite:	0	1	2	3	4	5	6	7	8	9	10	
9. Digestion/Bowel (BM):	0	1	2	3	4	5	6	7	8	9	10	
10. # of complaints:	0	1	2	3	4	5	6	7	8	9	10	
11. Colds/Infections:	0	1	2	3	4	5	6	7	8	9	10	
12. Breathing:	0	1	2	3	4	5	6	7	8	9	10	
Questions/Concerns/Other:												

#### This section is to indicate areas of DISCOMFORT and DYSFUNCTION in the body.

Please use the letter **N** for <u>NECK</u>, **M** for <u>MID BACK</u>, and **L** for <u>LOW BACK</u>. If you have challenges in other areas, please write the letter **X**, and indicate that body region here: \_\_\_\_\_\_(ex: X=Shoulder). For each of the 11 scenarios below, rate your discomfort in <u>each</u> body region by writing the letters **N**. **M**. and **L** (and **X** if applicable)—**even if you have no discomfort/dysfunction in that area**. See example below.

EXAMPLE:		(Mid back)				eck)		(Low back)			
Travel (Driving, etc.)	0	<u> </u>	2		<u> N</u>	6_			_10		
		No discomfort	Sc	ome	Mild		Moderate	Severe	Worst discomfort		
1. Discomfort Intensity	0_		2	4	1	6_	8	8	_10		
		No discomfort		ome	Mild		Moderate	Severe	Worst discomfort		
2. During Sleep	0_				<b>1</b>		3		_10		
		·		,	Mildly disturb		loderately disturbed	Greatly disturbed			
3. Personal Care (Washing, Dressing, etc.)	0_	No challenges	2	4 0 < 100%	LCan do 75%	6_	<b>8</b> Can do 50%	Need assistance	_ <b>10</b> Cannot do at all		
	•					~					
4. Travel (Driving, etc.)	0_	No discomfort	<b>2</b> Sc	4 ome	<b>1</b> Mild	6_	<b>K</b> Moderate	Severe	_ <b>10</b> Worst discomfort		
5. Work	•		2		1	c			10		
5. WORK	U_	Can do 100% + extra	a Can d	do 100%	•Can do 75%		Can do 50%	Can do 25%	Cannot work at al		
5. Recreation	0		2	4	1	6	8	3	_10		
	-	Can do all + more	Can	do 100%	Can do 75%		Can do 50%	Can do 25%	Cannot do any activit		
7. Discomfort Frequency	0_		2	4	1	6_	8	8	_10		
		No discomfort	Infre	quently	Occasionally		Intermittently	Frequently	Constant discomfor		
8. Lifting	0_		2		1		8		_10		
		No restrictions	Some	trouble		-	annot lift moderate	Cannot lift light	Cannot lift any weigh		
9. Walking	-		2		1			8	_10		
		,	0		U		0	0	Cannot walk		
10. Standing	-	o challenge > 3+brs					Challenge > 1hr	Challenge > 30mir	_ <b>10</b>		
		C C		-	Ū		C C	-			
11. Sitting			2				Challenge > 1hr	Challenge > 30mir	_ <b>10</b> Cannot sit		
Practico Mombor Signaturo		-		-	-		-	0			
Practice Member Signature:								Date			
Dr. Signature:								Deter			